Senate Budget & Fiscal Review

Senator Wesley Chesbro, Chair

Subcommittee No. 3
on
Health, Human Services, Labor, & Veterans Affairs

Senator Wesley Chesbro, Chair
Senator Gilbert Cedillo
Senator Tom McClintock
Senator Bruce McPherson
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April 21, 2003

2:30 PM *or* Upon Adjournment of Session

Room 4203

(Diane Van Maren, Consultant)

Item	*Description*
4260	**Department of Health Services—*Selected Public Health Issues (as noted) and Serostim funding in the Medi-Cal Program***

Note: Only those items listed in today's agenda will be heard today. The DHS will be discussed again as **noted in the Senate File, including at the time of the May Revision.** Thank you.

Note: Today's Hand Out package primarily consists of the Administration's proposed trailer bill language. If you do not obtain a copy of this package today (limited copies available), please obtain copies of the Administration's proposed trailer bill language by contacting either the DHS or DOF directly. Thank you.

Pursuant to the Americans with Disabilities Act, individuals who, because of a disability, need special assistance to attend or participate in a Senate Committee hearing, or in connection with other Senate services, may request assistance at the Senate Rules Committee, 1020 N Street, Suite 255 or by calling 916-324-9335. Requests should be made one week in advance whenever possible.

4260 Department of Health Services—*Selected Public Health Issues*

ACTION ITEMS FOR CONSENT—Spring Finance Letters *(Items 1 Through 3)*

General Public Information: The purpose of the Subcommittee process is to amend the Governor's proposed January budget as deemed appropriate. If an amendment is not taken on a particular issue as contained in the Governor's proposed January budget, the issue is, by the nature of the budget process, "approved as budgeted" for inclusion in the Budget Bill (in this case, the Senate version of the Budget Bill).

Spring Finance Letters are proposed amendments by the Governor to his January budget. If the Subcommittee adopts a Spring Finance Letter, it is included in the proposed Budget Bill. However if a Spring Finance Letter is not acted upon (i.e., no action) by the Subcommittee, the issue is not included in the Budget Bill. In other words, the Subcommittee must take an affirmative action on a Spring Finance Letter for it to be included in the Budget Bill (in this case, the Senate version of the Budget Bill).

1. Reversal of the Governor's Proposal Regarding Domestic Violence Prevention (Shifts GF back to the OCJP)

Governor's Proposed Budget and Finance Letter: The Governor's January budget for 2003-04 proposed to transfer $9.1 million (General Fund) in domestic violence prevention programs from the Office of Criminal Justice Planning (OCJP) to the DHS. **However upon this unveiling in January, it was realized that the proposal was premature.** Pursuant to Chapter 89, Statutes of 2002, the Secretary of the State and Consumer Services Agency is in the process of reviewing the services available to victims of crime on a statewide basis.

As such, the Administration is requesting to rescind its earlier budget transfer proposal through a Finance Letter. **Therefore, the $9.1 million (General Fund) proposed to be transferred to the DHS would be deleted and returned to the OCJP to continue to operate their programs for the budget year.**

Subcommittee Staff Comment: Subcommittee staff concurs with the Finance Letter and recommends its adoption.

2. Lung Disease and Asthma Research Pass-Through (Special Fund)

Background and Finance Letter: The DHS is requesting an **appropriation of $183,000 (California Lung Disease and Asthma Research Fund) to meet the mandates of AB 2127, Statutes of 2002.** These funds are obtained through a voluntary tax check-off. The requested appropriation will enable the DHS to disburse the funds as required to the American Lung Association of California. The American Lung Association of California may then use the funds to provide research grants to develop and advance the understanding, causes, techniques and modalities effective in the prevention, care treatment and cure of lung disease.

Subcommittee Staff Comment: Subcommittee staff concurs with the Finance Letter and recommends its adoption.

3. Electronic Death Registration (Special Fund)

Background and Finance Letter: Chapter 857, Statutes of 2002 (AB 2550, Nation), mandates the DHS to, among other things, develop and maintain an Electronic Death Registration System. AB 2550 provided for increased revenues for this purpose.

The Finance Letter is requesting legislative authority to appropriate **an increase of $2 million (Health Statistic Fund) in order to accomplish the design, development, implementation and training for the statewide conversion to an Electronic Death Registration System. As required by statute, the system is to be implemented by January 2005.** According to the DHS, the new system will provide timely death data, cross matching with birth certificates for anti-fraud purposes, allow online verification of decedents' social security number and allow online access to fact-of-death information within 24-hours of the occurrence of the death.

The DHS states that the project will be completed through an interagency service agreement with the University of California at Davis (UCD). Specifically, the UCD will design, develop and host the application, install the various servers and work closely with the DHS regarding security precautions. No one should be able to abscond with death or its data.

Subcommittee Staff Comment: The Subcommittee staff recommends approval of the Finance Letter. No issues have been raised for this special fund project.

ITEMS FOR DISCUSSION

1. AIDS Drug Assistance Program (ADAP) *(See Hand Out)*

Background--ADAP: The AIDS Drug Assistance Program (ADAP), established in 1987, is a subsidy program for low and moderate income persons (individual income cannot exceed $50,000) with HIV/AIDS who have no health insurance coverage for prescription drugs and are **not eligible** for the Medi-Cal Program. **There are about 26,000 clients enrolled in ADAP.**

Under the program eligible individuals receive drug therapies through participating local pharmacies under subcontract with the statewide contractor. The state provides reimbursement for drug therapies listed on the ADAP formulary (**about 146 drugs currently**). **The formulary includes anti-retrovirals, hypolipidemics, anti-depressants, vaccines, analgesics, and oral generic antibiotics.**

ADAP is cost-beneficial to the state. Without ADAP assistance to obtain HIV/AIDS drugs, **infected individuals would be forced to (1)** postpone treatment until disabled and Medi-Cal eligible or **(2)** spend down their assets to qualify for Medi-Cal. About 50 percent of Medi-Cal costs are borne by the state, as compared to only 30 percent of ADAP costs. Since the AIDS virus can quickly mutate in response to a single drug, medical protocol now calls for Highly Active Antiretroviral Treatment (HAART) which minimally includes three different anti-viral drugs. As such, expenditures in ADAP have increased.

The DHS notes that ADAP has grown in response to (1) increased demand brought about, in part, by the development of new, more efficacious but costly therapies, (2) increased caseload, and (3) changes in drug utilization as therapies shift due to drug resistance over the course of treatment as individuals live with AIDS.

Pharmacy Benefit Manager: In 1997, the DHS contracted with a pharmacy benefit manager to centralize the purchase and distribution of drugs under ADAP. According to the DHS, most recently, Ramsell Corporation has successfully completed the second year of a five-year contract with ADAP. Presently there are about 300 ADAP enrollment sites and about 3,100 pharmacies available to clients located throughout the state.

Governor's Proposed Budget: **Total ADAP funding is proposed to be $186.4 million ($60.5 million General Fund, $92.6 million federal Ryan White CARE Act Title II funds, $33.2 million in mandatory drug rebates from the manufacturers) for the budget year.**

The proposed budget reflects a *net increase* of $2.3 million (total funds) over the current year appropriation. This net increase consists of the following proposed components:

- Reduction of $7.2 million (General Fund) to reflect **implementation of the Administration's proposed copay legislation**;
- Increase of $8.3 million (General Fund) to make adjustments to the ADAP funding base;
- Increase of **$8 million *(one-time only)*** in drug manufacturer rebates, which have recently been collected, to offset General Fund support; **and**
- Increase of **$1.240 million in drug manufacturer rebates which will be on-going. This assumes that the DHS will be able to obtain an *average* rebate about 13 percent.**

The table below reflects the Administration's proposed actions:

Governor's Proposal	**General Fund**	**Federal Funds**	**Drug Rebates**	**New Copay Proposal**	**Total**
Budget Act of 2002	$67.4 million	$92.6 million	$24 million		$184 million
Increases	**$8.3 million**		**$9.2 million ($8 million is one time only)**		$17.5 million
Reductions	(-$15.2 million) ($8 million drug rebate & $7.2 million Copay)		($8 million offset to GF)	**($7.2 million offset to GF)**	(-$15.2 million)
Proposed 2003-04	**$60.5 million**	**$92.6 million**	**$33.2 million**	**Informational $7.2 million**	**$186.4 million**

The Administration's copay proposal would establish a three-tiered income-based system to require ADAP clients to assume a copay obligation on a per prescription basis ($30, $45 or $50 per script). ADAP clients with incomes of 200 percent of poverty or less would be exempt from the copay requirements. **Based on the information provided by the DHS, about 6,000 ADAP clients, or 24 percent of the total clients, would be affected by the proposed Copay.**

Under the Administration's proposed copay mechanism, ADAP clients would pay the proposed copay directly to the pharmacy. The amount paid by ADAP to pharmacies would then be reduced by the copay amount. Presumably, if the ADAP client does not pay their Copay for the prescription, the ADAP client will not obtain their medication.

The table below outlines how the DHS derived its estimate of savings for the proposed Copay.

Poverty Level	Estimated Clients	Percent Of Clients	Estimated Scripts	Copay Per Script	TOTAL Estimated Copay
100% or less	10,851	43.41%	338,607	$0	$0
101% - 200%	8,151	32.60%	255,284	$0	$0
201% - 300%	3,708	14.83%	126,926	$30	**$3,807,790**
301% - 400%	1,930	7.72%	68,106	$45	**$3,064,768**
400% or more	269	1.08%	8,862	$50	**$443,077**
Unknown	90	0.36%	929	$0	N/A
TOTAL	**25,000**	**100.00%**	**798,713**		**$7,315,636 Maximum Level**

According to the DHS information **an *average individual* between 200 and 300 percent of poverty could be expected to pay *about $1,026 annually* for their prescriptions ($30 per). Using the sliding fee scale, an average individual between 300 and 400 percent of poverty would pay about $1,588 annually.**

Constituency Concerns: The Subcommittee is in receipt of several letters from HIV/AIDS advocacy organizations which oppose the Administration's Copay proposal. First, they note that while most Californians with health insurance have pharmacy copays as part of their health benefits plan, individuals with HIV/AIDS who qualify for ADAP have far more limited means and far greater medical needs than the average Californian. Second, they contend that the Copay would force some individuals to go without needed medications, or take medications irregularly leading to more of the disabling and costly conditions associated with full-blown AIDS. Further, it is believed that when clients choose between drugs, rent or food, **there will be decreased treatment adherence, and thereby potentially increasing individual and community drug resistance.**

Subcommittee Staff Comment—Options Other Than Copay May Be Available: The Governor's proposed Copay proposal seems particularly onerous given the level of copayment required—an ***average*** **of from $ 1,026 to $1,588—though it would be contingent upon the number of prescriptions one needs at any given point in time.**

It is interesting to note that under the Medi-Cal Program, Medi-Cal recipients are asked to provide a copay (from $1 to $3) for prescriptions; however, federal law precludes any Medi-Cal provider (pharmacist, physician or other practitioners) from denying a medical service due to any lack of copayment by the recipient. Therefore if an ADAP client (drugs only) becomes sick enough to qualify for Medi-Cal (generally the "disabled" category), they could not only receive their drugs, but all other needed medical services as well. As such, this proposal seems to go against one of the original tenants of developing the program—provide necessary drug assistance to uninsured, low-income HIV/AIDS diagnosed

individuals in order to facilitate these individuals to live productive lives, including working.

It should be noted that the federal government has recently notified California that an additional $2.8 million in federal funds is to become available through the Ryan White CARE Act allocations (done in March). These additional resources have not been captured in this ADAP proposal due to the timing and release of the Governor's budget. As such, consideration of these additional funds for ADAP needs to be considered at the May Revision.

Additional options for generating resources should also be addressed, such as reviewing the level of drug manufacturer rebates received from each of the manufacturers and evaluating if additional leverage could be applied. Further, additional program efficiencies should be considered prior to implementation of a Copay, such as more follow-up regarding third-party payer availability. Lastly, the Administration could opt to limit participation in the program such as by instituting waiting lists, placing caps on per-client drug costs, and/or implementing formulary restrictions are other options, though clearly difficult in their own way.

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1.** Is it likely that California will be receiving **additional federal funds above the proposed budget level** for the ADAP for SFY 2003-04? **If so, what is the potential increased amount?**
- **2.** Please briefly describe how drug rebates are obtained. **Is it likely that additional drug rebates will be obtained in the budget year?**
- **3.** Please **briefly describe the Governor's Copay proposal.**
- **4.** Under the Administration's proposal, **would an ADAP client be denied their needed medications if the client were not able to pay the Copay?**
- **5. From a technical assistance perspective, please describe other cost containment measures that may be viable in order to reduce expenditures in ADAP.**

Budget Issue: Does the **Subcommittee want to request for the DHS to report back to the Subcommittee on additional cost-containment measures, and potential for increased drug rebates and federal funds in lieu of the Copay proposal?** If so, it is recommended to with hold action on this proposal pending receipt of the requested DHS information and the Governor's May Revision.

2. Limitation of Serostim (Medi-Cal Program)

Background: Serostim **is a human growth hormone that is on the Medi-Cal Contract Drug List and also on the AIDS Drug Assistance Program (ADAP) formulary.** Generally, the drug is used to mitigate extreme weight loss due to a medical condition, particularly if an individual is experiencing HIV/AIDS wasting syndrome. The drug can also be misused by body builders and others who are not experiencing a medical condition.

Governor's Proposed Budget and Trailer Bill Language: The estimate for Medi-Cal assumes a **reduction of $7.5 million ($3.750 million General Fund) by limiting whom is eligible to prescribe the drug. Specifically, the DHS is seeking trailer bill language to limit the prescriber network to physicians who are HIV specialists.**

The Subcommittee has received two versions of the proposed trailer bill language—the original one was dated February , 2003 and a revised version is dated March 17, 2003 (in the Hand Out). However, the Subcommittee has been recently advised that the Administration is *rescinding all* previously proposed trailer bill language for they intend to put Serostim on 100 percent "prior authorization" *effective June 1, 2003*. The Administration notes that Section 51313.3 of W&I Code enables the DHS to place a "Code 1" restriction (i.e., must be prior authorized) on Serostim, as well as other drugs.

Subcommittee Staff Comment: Subcommittee **staff concurs with the need to more effectively control the utilization of Serostim** and agrees that the DHS has existing statutory authority to proceed with placing Serostim on 100 percent prior authorization. **However due to the proposed change in approach, it is recommend for the Administration to report back to the Subcommittee at the time of the May Revision on any additional cost savings which are attributable to proceeding with this new method of utilization control. Subcommittee staff would contend that this new approach should result in additional General Fund savings.**

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1.** Please **provide a brief description of the Administration's revised proposal.**
- **2.** Is there **a consistent policy between the Medi-Cal Program and ADAP programs** regarding the prescribing and usage of Serostim?
- **3.** Does the **Administration have any intention of using identified savings from this proposal to off-set *any* expenditures in the ADAP?**

3. Governor's Proposed Public Health Realignment

Governor's Proposed Budget—Summary Overall: The Governor's proposed Realignment package consists of **four components in the health and human services area (over $7.9 billion), plus a court security plan for the Trial Courts ($300 million), for total expenditures of $8.2 billion.** The proposed new dedicated Realignment **revenues would stream from an increase in the Sales Tax (one percent), an increase in Personal Income Tax (10-11 percent bracket) and an increase in the Tobacco Excise Tax ($1.10 increase).**

The Administration proposes trailer bill legislation for each of these components. At this juncture, the language is crafted broadly to express the Legislature's intent to enact legislation to **(1)** transfer the specified program and its non-federal share of expenditures, **(2)** maintain state oversight of said programs, and **(3)** become operative only if dedicated revenues are enacted for this purpose.

The proposal assumes that 2003-04 fiscal allocations to counties would be based on the proposed level of funding for counties for each of the programs, absent Realignment, in order to avoid program disruptions in the budget year. However for 2004-05, the Administration assumes that a single allocation would be made to counties based on a formula to be developed through discussions. **As such, this would potentially serve as a type of "block grant" to the counties whereby the counties could conceivably shift funding across programmatic areas.**

Governor's Proposed Public Health Realignment: The Administration proposes to realign several programs **in the overall public health area for a total fund shift of $143.3 million (savings of $66.6 million General Fund, and a fund shift of $18.7 million in federal funds and $58 million in Proposition 99 Funds).**

This includes the following programs and their expenditures (total funds):

- Expanded Access to Primary Care(EAPC) $30.3 million (total funds)
- Indian Health Program $6.5 million (General Fund)
- Rural Health Clinic & Clinic Grants in Aid $ 8.8 million (General Fund)
- Seasonal Agricultural & Migrant Workers Program $ 6.9 million (General Fund)
- Adolescent Family Life Program $22.2 million (total funds)
- Black Infant Health Program $ 8 million (total funds)
- Local Health Department –Maternal & Child Health $ 7.4 million (total funds)
- County Health Services Public Health Subvention $ 2 million (total funds)
- California Healthcare for Indigent Persons Program $46 million (Proposition 99)
- Rural Health Services $ 4.3 million (Proposition 99)
- Managed Care Counties $926,000 (Proposition 99)

Prior Subcommittee Hearings--Informational: It should be noted that the Subcommittee has convened two informational hearings regarding the Governor's realignment proposal. In both hearings considerable testimony was received regarding potential concerns if these public health transfers were enacted. In addition, the Subcommittee has already taken action to reverse the Governor's realignment proposal regarding mental health programs as well as Medi-Cal in order to have a level playing field from which to make determinations.

Subcommittee Staff Comment--Clinic Programs: The community clinic programs, including the EAPC, Indian Health, Rural Health Clinic, Seasonal Agricultural & Migrant Workers and Clinic Grants in Aid, are programs that provide funds to non-profit community-based clinics. **Generally, each of these programs operates through an application process whereby the DHS, using extensive clinic data, awards funding based upon patient levels of service, uncompensated care, level of historically under served populations and related factors. All of these programs are designed to provide assistance for underserved, often medically needy populations.**

These programs were never designed to be county-operated for several reasons. First, community-based clinics provide services to very low-income, uninsured individuals, including children, who have medical needs. These services are not county specific nor neatly bound by a geographic county line, for medical services are often regionally-focused and provided based on medical need and demand. **Second,** community-clinics are significant providers of health care to the uninsured in most counties, yet often receive a minor share of the county health care budget for their care. Therefore shifting funding may enable some counties to withdraw some portion of their own funds from this responsibility which would result in further erosion of safety net funding. **Third,** the programs allocate funds based upon data-driven needs. This requires the clinics who receive funding to analytically present their funding need. If these funds are transferred to the counties, the programs may end up being purely formula-driven and therefore, not responsive to changing demographics and medical service area needs. **It is recommended to not realign these programs.**

Subcommittee Staff Comment--Maternal & Child Health Programs: The Adolescent Family Life Program (AFLP) and Black Infant Health Program **are two highly successful, highly evaluated programs which have been in existence for numerous years.** Both programs utilize non-profit, community-based providers for services. Neither of these programs operate statewide. **Both serve selected, targeted geographic areas due to funding limitations and need.**

The AFLP provides counseling, education and support services for pregnant and parenting teens, including fathers, and their infants. **The Black Infant Health Program** conducts targeted, coordinated activities to address underlying causes of infant mortality, low birth weight and other poor reproductive health outcomes of high-risk African American women. The program also supports the development of projects that evaluate and refine effective models of practice in the areas of health behavior modification, prenatal care outreach, prevention, and the role of men in parenting. **It is one of the few state programs that directly addresses health disparities within the African American population.**

Both of these programs are operating well, have outcome measurements, utilize community-based experts and are not geographic-specific to counties. Further, the federal Title V Maternal and Child Health block grant funds require these programs to provide data and meet certain other federal requirements. These types of programs are more effectively operated with the state serving as the overall fiscal agent, not counties. **It is recommended to not realign these programs.**

***Subcommittee Staff Comment*--California Healthcare for Indigent Persons (CHIP) Program and Rural Health Services (RHS):** A key purpose of Proposition 99 funds is to fund medical services on behalf of those who are unable to pay. In addition, as directed by the Proposition itself, the **funds must be used to supplement and not supplant existing funding.** As such, the CHIP and RHS were initiated in 1989 as a legislative result of the passage of Proposition 99. **These two programs are intended to assist providers in funding their uncompensated care costs for providing needed health care services to indigent individuals.**

Existing state statute distributes Proposition 99 funds to the CHIP and RHS programs based on a formula which allocates moneys for hospitals, physicians and other types of providers for uncompensated indigent health care services. These funds are provider specific, not county specific. The funding for these two programs is small, not relevant to county boundaries and would require some modicum of additional monitoring (to determine supplementing versus supplanting) if passed to the counties. In addition, funding for both programs, particularly CHIP has significantly deteriorated over the past two years. For example, the Budget Act of 2002 appropriated a total of $89.7 million for CHIP whereas $46 million is proposed for 2003-04 for a reduction of over 52 percent. **It is recommended to not realign these programs.**

Budget Issue: Does the Subcommittee **want to reverse the Governor's proposed realignment** for the above specified public health programs in order to have a level playing field from which to make determinations?

4. Administration of the Rural Health Clinic Program, and Seasonal, Agricultural Migratory Workers Clinic Program—Contracts

Background: Existing statute provides for the Rural Health Clinic Program, and the Seasonal, Agricultural Migratory Workers Clinic Program. Both of these programs provide critical primary health care services to specified medically underserved populations.

For clinics to be eligible to receive grant funds under these programs, existing statute contains specific criteria that a clinic must meet. In addition, clinics are required by the DHS to (1) provide a scope of work for the grants, and (2) provide extensive data regarding the populations served, services provided and related information.

Currently, the DHS uses a Request for Application (RFA) process for these two grant programs. **Existing statute provides for the DHS to grant funding for *up to* three years per grant cycle. The current three-year grant cycle will end as of June 30, 2003.**

Subcommittee Staff Concern and Proposed Trailer Bill Language (See Hand Out): It has come to the attention of Subcommittee staff that it would be beneficial to modify existing Section 124555 and Section 124710 of W&I Code **to enable the DHS to provide for a minimum of three years for the grant period. As noted above, statute currently provides for up to three years. This change in statute would provide the DHS with the flexibility to extend grant agreements, if needed, on a temporary basis until such time that new RFAs can be completed and implemented.**

Undoubtedly this is a difficult budget year and the proposed Realignment of these two programs has added to the complexity of the decision making process as to how to proceed with the RFA. On the one hand if the programs are realigned, the DHS would need to potentially allocate funds to the counties for the clinics. On the other hand, Realignment may not occur and the DHS will need to be able to effectuate the RFAs as soon as feasible so the clinics can continue with their mission of providing health care coverage to underserved individuals. As such, the proposed modification would give flexibility to the DHS, if needed, as well as provide some assurance to the clinics that there will not be a gap in funding due to the lack of completion of any RFA process.

It should also be noted that funds for this program are, as always, contingent upon enactment of the annual Budget Act. The proposed language does not change that aspect.

Budget Issue: Does the Subcommittee want to adopt the proposed Subcommittee staff trailer bill legislation?

5. Child Health Disability Prevention Program and the Gateway—(*See Hand Out)*

Overall Background: The Child Health Disability Prevention (CHDP) Program **provides pediatric prevention health care services to (1)** infants, children and adolescents up to age 19 who have family incomes at or below 200 percent of poverty, and **(2)** children and adolescents who are eligible for Medi-Cal services up to age 21 (Early Periodic Screening Diagnosis and Treatment—EPSDT).

CHDP services play a key role in children's readiness for school. All children entering first grade must have a CHDP health examination certificate or an equivalent examination to enroll in school.

The benefit package provided under the CHDP-only program is limited to providing a physical examination, nutritional assessment, vision and dental assessments, hearing assessment, laboratory tests and immunizations. Local health jurisdictions work directly with CHDP providers (private and public) to conduct planning, education and outreach activities, as well as to monitor client referrals and ensure treatment follow-up. With respect to funding, services for children not eligible for Medi-Cal or Healthy Families are primarily funded with General Fund support.

CHDP Gateway—Budget Act of 2002: Through the Budget Act of 2002 the Administration, working closely with constituency groups and the Legislature, **crafted a Gateway proposal whereby children eligible for the CHDP Program can be pre-enrolled in either Medi-Cal or the Healthy Families Program.**

The purpose of this Gateway was generally two-fold. First it was intended to transition eligible children into the Medi-Cal or Healthy Families Program so comprehensive health care coverage could be provided. Second, it was intended to reduce CHDP expenditures (100 percent General Fund support) and to have children correspond their health care visits with a specified periodicity schedule.

The CHDP Gateway was modeled after other programs that use an online electronic screening application at provider sites to link individuals to coverage. In essence, this technology allows providers to complete application forms using an internet-based process or a point of service device to transmit an application for program eligibility.

Generally, here is how the Gateway process will work:

- CHDP provider screens children for CHDP eligibility using the new electronic application.
- During the screening process, the family will be asked if they would like to apply for Medi-Cal or the Healthy Families Program (HFP).
- **Provider checks for child's existing Medi-Cal/HFP eligibility status** (the Medi-Cal Eligibility Data System—MEDS) to determine if the child is already covered by these programs. **If not, the Gateway process will determine "pre-enrollment" eligibility for temporary fee-for-service Medi-Cal coverage (maximum of 60-days).**

- **Pre-enrollment through the Gateway is completed if MEDS has no record for the child.** The Gateway creates a record on MEDS using the CHDP eligibility screening information and assigns the child a Client Identification Number. **Before leaving the provider's office, the child is given an "immediate need" document with a Medi-Cal Benefits Identification Card (BIC) number that allows them to access services immediately (for up to 60-days).**
- **In order to obtain continuing health care coverage, the family must complete a full application and continue with the applicable Medi-Cal or HFP process.** The DHS will mail the joint application to the family to complete prior to the end of the temporary 60-days fee-for-service coverage. A reminder notice will be sent by the DHS 15-days before the end of this temporary period, if an application has not been submitted.

Summary of Development of CHDP Gateway and Implementation: The DHS states that the Gateway **will be up and operational as of July 1, 2003. Many key components have been completed or are on schedule for completion.** System changes to add CHDP Gateway eligibles to the Medi-Cal Eligibility Data System (MEDS) have been proceeding well. CHDP local program training, provider training, and EDS internal system's training are being done or are scheduled. It should be noted that the last date for using the old CHDP paper forms will be September 30, 2003. After this point, everything will operate through the Gateway.

Governor's Proposed Budget—CHDP-Only (See Hand Out): The Governor's budget proposes total expenditures of $16 million ($6.2 million General Fund) for the CHDP-only program **which reflects a reduction of $85.6 million ($27.6 million General Fund) primarily due to implementation of the Gateway.** No one has raised any issues regarding this funding level, including the Legislative Analyst's Office (LAO). Further, it is consistent with the enactment of the Budget Act of 2002 and its accompanying trailer bill legislation.

Constituency Idea to Improve the Gateway—Deemed Eligible Infants: The DHS and constituency groups, including providers of services, have been working diligently through regular meetings of a CHDP Advisory Group. **Through this process, constituency interests have identified a few areas in which the CHDP Gateway could be improved. One of these areas of interest pertains to the enrollment of newborns through the Gateway process.**

While the Medi-Cal Program has existing statutory authority (Section 14011.4, of W&I Code) to perform the enrollment of newborns, the statutory authority of the CHDP Gateway is strictly limited to performing eligibility determinations for either the CHDP-Only eligibility or pre-enrollment eligibility funded either through Medi-Cal or the Healthy Families Program.

Based on technical assistance obtained from the DHS, to include newborn enrollment as part of the CHDP Gateway process an increase of $785,000 ($196,000 General Fund) is needed for 2003-04-- the first year expenditure which includes some one-time-only system development costs. *The DHS states that on-going expenditures would be $128,000 ($32,000 General Fund) annually.* As noted by the DHS, the establishment of this process is not expected to significantly change the services Medi-Cal pays for newborns.

In addition, statutory change would be needed (to Section 14011.4 of W&I code) to perform the newborn enrollment. Suggested language is as follows:

> Proposed New subdivision to Section 14011.4:
>
> "(b) In addition t the implementation of a program of pre-enrollment of children into Medi-Cal or Healthy Families programs as described in subdivision (a), the department may, at its option, use the electronic application described in subdivision (c) to also serve as a means to enroll newborns into the Medi-Cal Program as is authorized under 42 United States Code section 1396a(e)(4)."

Constituency groups note that by making this small modification to the Gateway, barriers to the enrollment of newborns would be low and infants would start to receive more timely health care coverage.

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1.** Please **provide a brief summary as to how the CHDP Gateway will work**.
- **2.** Please describe **(from a technical assistance basis) what would be needed to include newborn enrollment into the CHDP Gateway.**
- **3. From a technical assistance basis, would this revision to the Gateway make sense to implement?**

6. Genetically Handicapped Persons Program (GHPP)—Local Assistance & State Administration *(See Hand Out)*

Background—Services Provided and Reimbursement: The GHPP **provides diagnostic evaluations, treatment services, and medical case management services for adults with certain genetic diseases**, including cystic fibrosis, hemophilia, sickle cell disease, Huntington's disease, and certain neurological metabolic diseases. **The services covered by the GHPP include all the medically necessary medical and dental services needed by the client, not just the services related to the GHPP-eligible condition. (GHPP differs from the California Children's Services (CCS) Program in that CCS covers only services related to the CCS eligible condition.)**

GHPP is suppose to be the "payer of last resort" (as a 100 percent General Fund program) meaning that third-party health insurance and Medi-Cal coverage are to be used first. GHPP authorized services are **reimbursed according to the following guidelines** established by the DHS:

- **For GHPP-only clients** (non-Medi-Cal eligible) with **no health insurance**, GHPP reimburses providers using **solely General Fund support at Medi-Cal fee-for-service rates with claims adjudicated through EDS (state's fiscal intermediary);**

- GHPP clients with health insurance are required to use their health insurance first before GHPP state support is used. **Providers are to bill third-party health insurance first for these clients;**
- **Medi-Cal clients enrolled in GHPP may be enrolled in Medi-Cal Managed Care plans *or* be in fee-for-service Medi-Cal and are provided assistance as follows:**
    - **Managed care Medi-Cal clients** are only eligible for GHPP special care center team assessment and evaluation services which are reimbursed fee-for-services. All other benefits are covered by the health plans under the managed care arrangement.
    - Fee-for-service Medi-Cal clients have services paid by Medi-Cal but are case managed by GHPP.

Background—Hemophilia and Its Treatment: Generally, patients with hemophilia refers to a group of bleeding disorders, most commonly "factor 8" and "factor 9" deficiencies but also include von Willebrands Disease and other "factors". Patients with these disorders are classified based on their level of procoagulant that is deficient. Disease management through comprehensive hemophilia treatment centers is often recommended.

Individuals with these disorders require treatment **with factor concentrates for bleeding episodes. These factor concentrates are medications that are either made through purification of plasma proteins or through a process of genetic engineering. These products are clinically complex and cannot be considered interchangeable. Prescriptions are usually written as brand name prescriptions after discussion of the particular product between patient and caregiver.**

It should be noted that about 83 percent, or almost $30 million **of the total proposed expenditures for 2003-04 is needed for program clients with Hemophilia.**

Ever Increasing Expenditures for the GHPP: **Expenditures for the GHPP have been rapidly increasing over several years as noted in the chart below.** In fact, the program **increased well over 320 percent from 1996 to 2001** (the last year that actual expenditures are available).

Fiscal Year	Actual General Fund Expenditures
1996-97	$12 million
1997-98	$16.5 million
1998-99	$23.8 million
1999-2000	$34.9 million
2000-01	$31.2 million
2001-02	$38.8 million
2002-03	$32 million (plus $6.6 million in drug rebates)
2003-04	$28.5 million (plus $7.6 million in drug rebates)

According to the DHS, the primary reasons for the rapidly rising costs are:

- **Increases in blood factor expenditures for the hemophilia population which is due to conversion to more expensive manufactured recombinant factor products rather than less expensive plasma derivatives and more aggressive prevention and treatment interventions**;
- **Use of GHPP funds** to pay for services that **should have been paid by other third party payers because:**
    - Annual determinations of clients for the availability of other health care coverage are delayed for months or not done at all; and
    - Lack of staff to appropriately review provider claims for other third party sources of reimbursement by checking for the client's most recent information on insurance coverage if annual determination has been timely and completed;
- Inability to assess and collect client fees;
- Increasing enrollment of persons with marginally eligible conditions (i.e., clients who are not handicapped or even ill from their GHPP-eligible diagnosis).

Budget Act of 2002: Through the Budget Act of 2002, **authority was provided to the DHS to negotiate drug rebates for blood factor products under the GHPP (Section 125190 of Health & Safety Code).** Generally the language enabled the DHS to receive manufacturers' discounts, rebates, or refunds based on the quantities purchased under the GHPP. It is anticipated that $6.4 million in General Fund support will be obtained from this authority.

In addition under the Medi-Cal Program, the trailer legislation provided for contracting authority for medical supplies (Section 14105.3 of W&I Code). Generally, this language **granted the DHS authority to, among other things, enter into exclusive or nonexclusive contracts on a bid or negotiated basis** with manufacturers, distributors, dispensers, or suppliers of appliances, durable medical equipment, medical supplies and other product-type health care services and with laboratories for clinical laboratory services for the purpose of obtaining the most favorable prices to the state and to assure adequate quality of the produce or service.

Governor's Proposed Budget (See Hand Out): **The budget proposes expenditures of $36 million ($28.4 million General Fund, $160,000 enrollment fees and $7.4 million in drug rebates related to blood factor)** to provide treatment assistance to **about 910 average annual GHPP-only participants (an average annual cost of over $39,500 per case)**. **About 83 percent**, or almost $30 million **of the total proposed expenditures is needed for program clients with Hemophilia.**

The proposed budget reflects a *net* decrease of $2.5 million (decrease of $3.5 million General Fund and an increase of $1 million in drug rebate funds) over the revised current year budget.

In order to curtail expenditures, the Administration proposes the following adjustments:

- A **15 percent rate reduction (applies to 85 percent of the program base)**, effective July 1, 2003, for savings of **$4.2 million (General Fund);**
- An increase of $1 million, for a total of $7.4 million, **in drug rebates by contracting with all major blood factor manufacturers**;
- **Establishment of several cost contain measures as articulated in proposed trailer bill language**, **including implementation of utilization controls on blood factor products, assuring that other health care coverage is utilized prior to accessing the GHPP and implementing a more efficient system for the assessment and collection of client participation fees** for a total savings of $1 million (General Fund).

GHPP services affected by the proposed rate reduction include physician services, dental, orthodontia, pharmaceuticals, medical supplies, allied health professional services (for example vendored therapy), laboratory, and blood factor product. **The reduction will not** apply to inpatient services, outpatient services, hospice, and negotiated rate services such as some durable medical equipment.

In order to implement the above proposed changes, the DHS is seeking an increase to their state support budget by a total of $316,000 ($205,000 General Fund) proposed to be used as follows:

- **Hire three new positions**—Nurse Consultant II, Associate Governmental Program Analyst, and an Accounting Technician;
- **Contract with a consultant** for $100,000 ($61,000 General Fund) to **develop information and purchase pamphlets for clients on appropriate use of the GHPP**, **develop information and pamphlets for providers on appropriate claiming for blood factor**, **and assist with stakeholder meetings on revision and clarification of program eligibility regulations.**

The DHS states that a **Nurse Consultant II is needed to work collaboratively with hematology experts to develop authorization guidelines to assure blood factor is not being over prescribed by the GHPP special care centers or that expensive blood factor is being used when a less expensive product would be appropriate.** The proposed Nurse Consultant II would also review all GHPP requests for authorization of blood factor over $25,000. **In addition, this position would be used to revise existing GHPP regulations to more comprehensively define GHPP eligibility** and to articulate that services are to be available to those with severe illnesses who have exhausted all other affordable healthcare insurance options.

The proposed **Analyst position** would have responsibility to **(1) assure that annual determinations for the presence of other health care coverage were completed and that the information obtained is accurate and entered into the automated GHPP case management system**, and **(2) develop provider guidelines for blood factor providers on the appropriate billing of GHPP** to make certain that blood factor claims were being appropriately returned for insurance payment. **The DHS contends that a savings of five percent, or about $1 million**

(General Fund) would be achieved from these endeavors in the budget year, and about $2 million (General Fund) on an annual basis.

The proposed **Accounting Technician position would review all blood factor claims for a client and determine if other coverage is available. If so, the Accounting Technician would return the claim to the provider with instructions on billing the other insurance.**

Constituency Concerns: The Subcommittee has received information **expressing concerns with primarily three key components of the proposal—the 15 percent rate reduction, the contracting trailer bill legislation for the blood factor, and trailer bill language that provides the DHS with broad authority to contact out any service** ***(See Section 125190(a), page 7 of the Hand Out).***

Subcommittee Staff Comment: The conceptual framework proposed by the Administration to curtail expenditures in the GHPP makes sense. **It is suggested for the DHS, interested parties and Subcommittee staff to continue to work on trailer bill legislation regarding the contracting of blood factor products.**

However, the proposed trailer bill language that provides the DHS with broad authority to contract out any service, should be deleted. The budget identifies no savings from the proposed language and it is unclear as to what is intended.

Further, it is suggested to include the decision regarding the 15 percent rate reduction for the GHPP in tandem with the overall decision regarding the Governor's proposed 15 percent rate reduction under the Medi-Cal Program. (There needs to be consistency between programs and reimbursement levels for providers operating in both programs.)

With respect to the request for state staff, it is suggested to approve the three positions but to delete the $100,000 ($61,000 General Fund) for consultant services. The activities that would have been conducted by the consultant should be spearheaded by the GHPP **staff working collaboratively with associations and providers groups involved with issues that affect the GHPP client population, particularly those that pertain to the education and treatment of Hemophilia. The cooperation and assistance of interest groups is critical to the success of the proposed changes.**

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1.** Please briefly **explain the 15 percent rate reduction** and for what specific services this reduction will be applicable.
- **2.** Please briefly **explain the drug rebate and contracting proposal, including the trailer bill language. How have recent meetings with interested parties progressed?**
- **3.** Please briefly **explain the other cost containment measures, including the proposed trailer bill language.**
- **4. Please briefly describe the need for the requested positions.**

7. California Children's Services Program—The Administration's Proposals

Background—CCS: The California Children's Services (CCS) Program provides medical diagnosis, case management, treatment and therapy to financially eligible children **with specific medical conditions**, **including birth defects, chronic illness, genetic diseases and injuries due to accidents or violence**. **The CCS services must be deemed to be *"medically necessary"* in order for them to be provided.**

CCS depends on a network of specialty physicians, therapists and hospitals to provide medical care to financially eligible, enrolled children.

It is the oldest managed health care program in the state and the only one focused specifically on children with special health care needs. **By law, CCS services are provided as a separate and distinct medical treatment (i.e., carved-out service).**

Children enrolled in the Medi-Cal and Healthy Families programs are deemed to automatically meet income eligibility requirements for CCS. About 75 percent of the children receiving treatment services, or about 134,000 CCS clients, are estimated to be enrolled in both CCS and Medi-Cal, whereas an estimated 13 percent are enrolled in both CCS and the Healthy Families Program. The remaining 12 percent or so are CCS-only individuals.

CCS is jointly operated by the counties and the state. As such, County Realignment funds, state General Fund support, and federal funds (when applicable) are used to support the program.

Budget Act of 2000: Through the Budget Act of 2000, the CCS Program was provided a rate increase of 39 percent. Other than a five percent increase granted in 1999, no rate adjustment had been provided since 1982. **These rate adjustments resulted from data obtained from the Senate Office of Research and their comprehensive report on the program (published in 2000), plus rate analyses conducted by the DHS, as well as the American Academy of Pediatrics and specialty physician groups. As such, consideration of how the Administration's proposed 15 percent rate reduction would affect this program, needs to be given special consideration for conceivably, significant problems that were experienced previously, could potentially resurface if rates are reduced too signficantly.**

For example, it was documented that (1) many provider groups were having extreme difficulty retaining and hiring for pediatric subspecialty positions, (2) patients were experiencing tremendous waiting times to receive necessary subspecialty services (three months to a year depending on the service), and (3) patients in rural and suburban areas were having to travel long distances to find a doctor authorized by CCS.

Governor's Proposed Budget (See Hand Out): The budget proposes **total program expenditures of $141.4 million ($69.5 million General Fund, $61.5 million County Realignment Funds, $4.7 million federal Maternal & Child Health block grant funds, $2.6 million drug rebates, $260,000 patient fees, and $2.8 million other funds) for 2003-04.**

Key changes proposed by the Administration for CCS include the following:

- **Decrease of $3 million (General Fund) to reflect a 15 percent provider rate reduction effective July 1, 2003;**
- Implementation of **drug rebates for blood factor product for savings of $5.2 million ($2.6 million General Fund) effective July 1, 2003; and**
- **Establishment of several cost contain measures as articulated in proposed trailer bill language**, **including implementation of utilization controls on blood factor products.**

The Administration's proposals *generally* parallel the proposals contained under the GHPP (see item 6 in the Agenda, above). CCS services affected by the proposed rate reduction include physician services, dental, orthodontia, pharmaceuticals, medical supplies, allied health professional services (for example vendored therapy), laboratory, and blood factor product. **The reduction will not** apply to inpatient services, outpatient services (including CCS Special Care Center Services), hospice, and negotiated rate services such as some durable medical equipment.

The proposed trailer bill language for blood factor and other cost containment measures also is the same as for the GHPP.

In order to implement the above proposed changes, the DHS is seeking an increase to their state support budget of a total of $405,000 ($234,000 General Fund). The requested increase is to be used for **five new positions--**a Pharmaceutical Consultant II, two Associate Governmental Program Analysts, an Accounting Technician, and an Associate Information Systems Analyst.

The DHS states it intends to develop, implement, and operate a rebate/contracting program for drugs, medical supplies and durable medical equipment for CCS and GHPP in tandem with and parallel to the Medi-Cal Program.

They contend the positions are needed as follows:

- ***Pharmaceutical Consultant II (Medi-Cal Program):*** Among other things, this position will negotiate with manufacturers for CCS/GHPP drug rebates, and develop and oversee the fiscal intermediary'' development of the system changes necessary to operate a rebate system.
- ***Associate Governmental Program Analyst (Medi-Cal Program):*** Among other things, this position would coordinate the rebate program based on negotiated CCS/GHPP rebate contracts including oversight of invoicing and manufacturers' rebate payments, development of procedures and resolution of payment disputes.
- ***Associate Governmental Program Analyst (CCS Program):*** Among other things, this position would be responsible for (1) analysis of current product utilization by manufacturer, (2) provision of information on specific CCS and GHPP programs' operations in terms of

drug utilization, providers and claims processing and, (3) development of outreach materials and training of CCS providers and programs to assure maximum use of drugs subject to rebates when clinically appropriate.

- ***Accounting Technician (DHS Accounting Section):*** Among other things, this position would be responsible to identify the CCS/GHPP rebate checks, photocopy and route to the proper state accounting (CALSTARS) code for deposit, perform accounting functions related to tracking of claiming reimbursements from drug companies, and assign the appropriate distribution to county CCS programs and the state GHPP.
- ***Associate Information Systems Analyst (Medi-Cal Program):*** Among other things, this position would be responsible for oversight of the system changes needed to implement rebating for the CCS and GHPP programs through use of the existing DHS Rebate Accounting and Information System (RAIS). This system will allow for the automated generation of invoices for rebates due and tracking of invoice payments. This position will be responsible for ongoing performance monitoring of the RAIS as it pertains to CCS/GHPP.

Subcommittee Staff Comment: As **noted under the GHPP comments**, it is suggested **(1)** for the **DHS, interested parties and Subcommittee staff to continue to work on trailer bill legislation regarding the contracting of blood factor products, *and* (2) to delete the trailer bill language that provides the DHS with broad authority to contract out any service.**

Further, it is suggested to include the decision regarding the 15 percent rate reduction for the CCS in tandem with the overall decision regarding the Governor's proposed 15 percent rate reduction under the Medi-Cal Program. (There needs to be consistency between programs and reimbursement levels for providers operating in both programs.)

With respect to the requested staff positions, it is suggested to (1) approve the Associate Governmental Program Analyst for the Medi-Cal Contracting Section, the Pharmaceutical Consultant II to negotiate with the manufacturers for CCS and GHPP drug rebates and the Accounting Technician position, (2) redirect an existing Associate Governmental Program Analyst position within CCS to analyze product utilization and perform other functions, and (3) delete funds and position authority for the remaining two requested positions (i.e., the Associate Information Systems Analyst and the Associate Governmental Program Analyst).

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1. Please briefly describe the various aspects of the proposal.**
- **2. Please briefly describe the need for the requested positions. Please also describe why these five positions are needed in addition to the three positions requested under the GHPP proposal.**

8. Update on the Nine West Settlement Agreement & the Administration's Proposal on Gynecologic Cancer Information

Background—Nine West Settlement (Gynecologic Cancer Information Component): Through a nationwide class action settlement agreement (State of Florida, et al., versus **Nine West** Group, Inc.), **California received $2.9 million in funds (one-time dollars for expenditure through 2006)** for several programs, including law enforcement, domestic violence shelters, breast cancer **and gynecological cancer information.**

Existing statute provides for certain settlement funds to be placed into **non-budget-act special accounts. As such, the DHS funds were placed into a special account for expenditure.**

Of the amount the DHS received, **$500,000 was identified for expenditure for Gynecologic Cancer Information. The Nine West Settlement stipulated that funds *(Phase I)* were to be used to development a series of fact sheets and pamphlets to educate women about gynecological cancer, and pay for translation and field testing of the materials in six languages. In addition, it would also serve to encourage grants from other sources to fund physician education, public education and outreach *(Phase II)*.**

The Settlement also provides that any remaining unspent settlement funds, as well as interest, shall be directed to the Gynecologic Cancer Information program for use in Phase II activities. Information obtained from the DHS shows that about $62,000 in interest has been earned and that $130,000 in unexpended funds is available.

The DHS Office of Women's Health is utilizing these funds to complete a variety of activities, including (1) revising the English brochure, (2) translating and focus testing of brochure into Spanish, Vietnamese, Chinese, Korean, Cambodian, Hmong, Russian, Farsi, and Armenian, (3) printing and stocking the brochures, and (4) marketing and distributing the brochures to health care providers and others.

Governor's Mid-Year Reduction & Section 3.90—Eliminated Gynecologic Cancer Information Funding: The Governor's Mid-Year Reduction proposed to eliminate $150,000 (General Fund), as well as the statute, for the Gynecologic Cancer Information program. Though the Legislature rejected this proposal, **the Administration proceeded to eliminate the $150,000 (General Fund) through the DHS' Section 3.90 process.**

Under Section 3.90 of Chapter 1023, Statutes of 2002 (a trailer bill to the Budget Act of 2002), authority was provided to the Administration to reduce state support expenditures. Specifically, it required the Administration to reduce by up to 5 percent appropriations for state operations.

The DHS was allocated, by the Administration, a support reduction of $7.072 million. As part of this reduction, the DHS identified the $150,000 for Gynecologic Cancer Information for reduction. In mid-February, the DOF directed the State Controller to implement all Section 3.90 reductions. As such, the funds were eliminated.

Subcommittee Staff Comment: Due to the elimination of General Fund support and the availability of special fund moneys, it is suggested to appropriate $192,000 (special funds) to the Gynecological Cancer Information Program in the Budget Bill. This program corresponds to the requirements of the Nine West Settlement and it would make sense to appropriate the funds.

Budget Issue: Does the Subcommittee **want to appropriate $192,000 (special funds) in available Nine West Settlement funds for the Gynecologic Cancer Information Program?**

9. Richmond Laboratory Information Technology Support

Background: The Richmond Laboratory is a state of the art laboratory that was dedicated in April 2001. The Richmond Laboratory represents the consolidation of seven decentralized laboratories. This laboratory serves as major support for local, state and federal agencies that have public health and environmental enforcement roles. **DHS' laboratory services programs provide analytical, diagnostic, developmental, evaluative, epidemiological, reference, quality control, education, training and consultative laboratory services.**

The DHS states that the laboratories have both special needs and obligations with regard to information, data processing, and security requirements. They note that the laboratories require up-to-date information technology infrastructure and support at the Richmond campus. **They further articulate that the laboratories will produce information and databases upon which public and environmental policy is developed and through which regulatory action is taken to protect and promote public and environmental health. Finally, they note that the research performed at this campus is also a critical component in the department's ability to respond to bioterrorism threats.**

Governor's Proposed Budget: The budget proposes **an increase of $1.6 million ($864,000 General Fund, $254,000 in federal funds and $512,000 in various special funds) to connect some of the laboratory staff to the Local Area Network (LAN)/Wide Area Network (WAN) environment which, according to the DHS, provides access to departmental e-mail, calendars, servers, and program data.** It also provides access to health-related resources at the state's data centers, the internet, and connectivity to other state, federal, county, and local entities.

Specifically, the $1.6 million ($864,000 General Fund) request is for the following:

- $630,000 Network equipment
- $350,000 Servers
- $302,000 Installation and project management
- $348,000 Ongoing data center network and support

Subcommittee Staff Comments: Due to the lack of General Fund resources and the difficult choices regarding direct health care services, Subcommittee staff suggests to **(1) approve the request, minus the $864,000 in General Fund support**, and **(2)** direct the DHS to review the availability of other funding sources that may be suitable for this purpose, such as other federal funds for bioterrorism, or other special funds. **If the DHS identifies other applicable funding sources, they may inform the Subcommittee at May Revision for further consideration.**